DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03-011**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $1,812,500
b. FFY 2004 $7,250,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A pages 2 through 41.
Attachment 4.19-b, pages 2, 2-a, 2-b, 2-c, 2-d, 2-e, 4, 4-1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A pages 2 through 36.
Attachment 4.19-b, pages 2, 2-a, 2-b, 2-c, 4

10. SUBJECT OF AMENDMENT:

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
DENNIS BRADDOCK

14. TITLE:
Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Department of Social and Health Services
Attn: Ann Myers
Medical Assistance Administration
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Olympia, WA 98504-5533

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
April 19, 2005

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Dennis G. Smith

22. TITLE: Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

A. INTRODUCTION

The State of Washington's Department of Social and Health Services (DSHS) implemented a Diagnosis Related Groups (DRG) based reimbursement system for payment of inpatient hospital services to Medicaid clients in the mid 1980's. This system, as revised through this amendment, is used to reimburse for admissions on or after January 1, 2001. Revisions to this system are made as necessary through amendments to the State plan.

This plan incorporates revisions that eliminate all disproportionate share and pro-share programs involving intergovernmental transfers. These changes will be effective on July 1, 2005. This plan also incorporates a new payment methodology to be effective July 1, 2005 for public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center. The new payment methodology incorporates the use of certified public expenditures (CPEs) at each hospital as the basis for claiming federal Medicaid funding for medically necessary patient care.

The hospital rates and payment methods described in this attachment are for the State of Washington Medicaid program. The standards used to determine payment rates take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. The system includes payment methods to hospitals for sub-acute care such as skilled nursing and intermediate care, and payment methods for other acute inpatient care such as Long Term Acute Care (LTAC). The rates for these services are lower than those for standard inpatient acute care.

The reimbursement system employs four major methods to determine hospital payment rates: DRG cost-based rates; DRG contract rates; full cost rates (beginning on July 1, 2005); and rates based on hospitals' ratio of costs- to-charges (RCC).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

A. INTRODUCTION (cont.)

Other payment methods used include per member per month (PMPM) graduate medical education (GME) payments, fixed per diem, cost settlement, disproportionate share hospital (DSH), and proportionate share hospital. All are prospective payment methods except the cost settlement payment method used to reimburse critical access hospitals. Newborn screening tests approved through legislative direction are covered services reimbursed by the department and payment adjustments are made when necessary. The DRG,"full cost", and RCC payment methods are augmented by trauma care payment methods at state-approved trauma centers. The trauma care enhancement provides reimbursement to Level I, II, and III trauma centers through lump-sum supplemental payments made quarterly.

A fixed per diem payment method is used in conjunction with the LTAC program. A cost settlement payment method is used to reimburse hospitals participating in the state's Title XIX Critical Access Hospital (CAH) program. Monthly PMPM GME payments are provided by MAA directly to the University of Washington Medical Center and the Harborview Medical Center for GME related to Healthy Options care.

Contract hospitals participating in the federally waivered Medicaid Hospital Selective Contracting Program are reimbursed for services paid by the DRG payment method based on their negotiated DRG contract rate.

Hospitals not located in contract areas and hospitals located in a contract area that are exempt from selective contracting, are reimbursed for services paid under the DRG payment method using a cost-based DRG rate.

Non-contract hospitals in selective contracting program areas will be paid by MAA for inpatient services only when those services are determined by MAA to be emergency services.

Beginning on July 1, 2005, public hospitals located in the State of Washington, that are not department approved and DOH certified as CAH, are paid the "full cost" of Medicaid and GAUDSH covered services as determined through the Medicare Cost Report, using MAA's Medicaid RCC rate to determine Medicaid cost and the GAUDSH cost.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

A. INTRODUCTION (cont.)

Each public hospital district for its respective non-CAH public hospital district hospital(s), the Harborview Medical Center, and the University of Washington Medical Center, provide certified public expenditures which represent its costs of the patients' medically necessary care.

Hospitals and services exempt from the DRG payment methods are reimbursed under the RCC, "full cost", cost settlement, or fixed per diem payment method.

The following plan specifies the methods and standards used to set these payment rates, including: definitions; general reimbursement policies; methods for establishing: cost-based DRG rates; "full cost" reimbursement; RCC payment rates; CAH rates; fixed per diem reimbursement; Disproportionate Share Hospital (DSH) reimbursement; upper payment limits (UPL); UPL reimbursement; and administrative policies on provider appeal procedures, uniform cost reporting requirements, audit requirements, and public notification requirements.

B. DEFINITIONS

The terms used in this plan are intended to have their usual meanings unless specifically defined in this section or otherwise in the plan. Allowed charges, where mentioned in this attachment to the state plan, refers to the DSHS covered charges on a claim that are used to determine any kind of reimbursement for medically necessary care.

1. *Accommodation and Ancillary Costs*

Accommodation costs: the expense of providing such services as regular room, special care room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Ancillary costs: the expense of providing such services as laboratory, radiology, drugs, delivery room (including maternity labor room), and operating room (including anesthesia and postoperative recovery rooms). Ancillary services may also include other special items and services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

2. *Case-Mix Index (CMI)*

Case-mix index means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using DRG weights as a measure of relative cost.

3. *Critical Access Hospital (CAH) Program*

Critical Access Hospital (CAH) program means a Title XIX inpatient and outpatient hospital reimbursement program where instate hospitals, that are department approved and DOH Medicare-certified as a CAH, are reimbursed through a cost settlement method.

4. *DSHS or Department*

DSHS or department means the Department of Social and Health Services. DSHS is the State of Washington's state Medicaid agency.

5. *Diagnosis Related Groups (DRGs)*

DRG means the patient classification system originally developed for the federal Medicare program which classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

The DRGs categorize patients into clinically coherent and homogenous groups with respect to resource use. The Washington State Medicaid program currently uses The All Patient Grouper and has established relative weights for 400 valid DRGs for its DRG payment system. There are an additional 168 DRGs that are not used and another 241 DRGs with no weights assigned. Of the 241 DRGs with no weights, two are used in identifying ungroupable claims under DRG 469 and 470.

The remainder of the 241 DRGs are exempt from the DRG payment method. The All Patient Grouper, Version 14.1 has a total of 809 DRGs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

6. *Emergency Services*

Emergency services means services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

7. *HCFA/CMS*

HCFA means the Department of Health and Human Services' former Health Care Financing Administration (HCFA), renamed the Centers for Medicare and Medicaid Services (CMS) in June 2001. CMS, formerly named HCFA, is the federal agency responsible for administering the Medicaid program.

8. *Hospital*

Hospital means a treatment facility which is licensed as an acute care hospital in accordance with applicable State laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

9. *Inpatient Services*

Inpatient services means all services provided directly or indirectly by the hospital subsequent to admission and prior to discharge of an inpatient, and includes, but is not limited to, the following services: bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and, related services provided by the hospital within one calendar day of the client's admission as an inpatient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

10. Long Term Acute Care

Long Term Acute Care (LTAC) means prior authorized inpatient services provided directly or indirectly by a State designated Long Term Acute Care hospital. LTAC services are authorized, subsequent to patient admission, but after the treatment costs in a DRG paid case have exceeded high-cost outlier status. At the point at which that determination is made, the mode of care and reimbursement may switch to LTAC under a fixed per diem rate if authorized by DSHS. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care in or out of a hospital's intensive care unit.

The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient.

The LTAC services include, but are not limited, to: bed and board; services related to medical, nursing, surgical, and dietary needs; IV infusion therapy, prescription and nonprescription drugs, and/or pharmaceutical services and total parenteral nutrition (TPN) therapy, up to two hundred dollars per day in allowed charges; and medical social services furnished by the hospital.

11. *MI/GAU*

MI/GAU, as used in Paragraph F.2 and F.3 below, means the DSHS Limited Casualty Program-Medically Indigent (MI) or General Assistance Unemployable (GAU) services.

12. *RCC*

RCC means a hospital ratio of costs-to-charges (RCC) calculated using annual CMS 2552 Medicare Cost Report data provided by the hospital. The RCC, not to exceed 100 percent, is calculated by dividing adjusted operating expense by adjusted patient revenues. The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services. A reduced RCC is used to calculate MIDSH and GAUDSH payments on RCC paid claims.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

13. *Operating, Medical Education and Capital Costs*

Costs are the Medicare-approved costs as reported on the CMS 2552 and are divided into three components:

Operating costs include all expenses, except capital and medical education, incurred in providing accommodation and ancillary services; and,

Medical education costs are the expenses of a formally organized graduate medical education program; and,

Capital-related costs include: net adjusted depreciation expenses, lease and rentals for the use of depreciable assets, costs for betterment and improvements, cost of minor equipment, insurance expenses on depreciable assets, and interest expense and capital-related costs of related organizations that provide services to the hospital. Capital costs due solely to changes in ownership of the provider's capital assets on or after July 18, 1984, are deleted from the capital component.

14. *Uninsured Indigent Patient*

Means an individual who receives hospital inpatient and/or outpatient services and the cost of delivered services is not met because he/she has no or insufficient health insurance or other resources to cover the cost. The cost of services for uninsured indigent patients is identified through the hospital's charity and bad debt reporting system.

Charity care and bad debt, as defined by the Department of Health through its hospital cost reporting regulations WAC 246-453-010, (4) "INDIGENT PERSONS" (Supplement 1 to Attachment 4.19-A, Part I, Pages 1 through 10) and chapter 70.170 RCW "HEALTH DATA AND CHARITY CARE" (Supplement 2 to Attachment 4.19-A, Part I, Pages 1 through 11), means those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200 percent of federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer; (5) "Charity care" means appropriate hospital-based medical services provided to indigent persons, as defined in this section.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

Services covered by an insurance policy are not considered an uninsured covered service.

15. *Cost Limit For DSH Payments*

For the purpose of defining cost under the DSH program a ratio of costs-to-charges (RCC) is calculated prospectively using annual CMS 2552 Medicare Cost data. The RCC is applied through a prospective payment method to historical total hospital billed charges to arrive at the hospitals total cost.

16. *DSH One Percent Medicaid Utilization Rate*

All hospitals must meet the one percent Medicaid inpatient utilization in order to qualify for any of the DSHS disproportionate share programs.

17. *DSH Limit*

The DSH limit in Section B.15 is applicable for public hospitals. In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost, except as allowed by subsequent federal guidelines.

18. Trauma Centers

Trauma Centers are designated by the State of Washington Department of Health (DOH) into five levels, based on level of services available. This includes Level I, the highest level of trauma care, through Level V, the most basic trauma care. Level of designation is determined by specified numbers of health care professionals trained in specific trauma care specialties, inventories of specific trauma care equipment, on-call and response time minimum standards, quality assurance and improvement programs, and commitment level of the facility to providing trauma related prevention, education, training, and research services to their respective communities.

19. *PII--Psychiatric Indigent Inpatient*

Means DSHS Limited Casualty Program-Psychiatric Indigent Inpatient (PII) services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

B. DEFINITIONS (cont.)

20. *"Full Cost" Public Hospital Certified Public Expenditure (CPE) Payment Program*

"Full cost" public hospital certified public expenditure (CPE) payment program means a hospital payment program for public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center. These hospitals are reimbursed based on the full cost of services as determined through the Medicare Cost Report and MAA's RCC rate. Each of these hospitals certified public expenditures represent the costs of the patients' medically necessary care. Each hospital's Medicaid and GAUDSH claims are paid by the "full cost" payment method, using the Medicaid RCC rate to determine Medicaid cost and the GAUDSH cost.

21. *Peer Groups*

Peer groups mean MAA designated peer groups. MAA's peer grouping has six classifications: Peer group A, which are rural hospitals paid under an RCC methodology; peer group B, which are urban hospitals without medical education programs and which are not in peer group E; peer group C, which are urban hospitals with medical education programs and which are not in peer group E; peer group D, which are specialty hospitals and which are not in peer group E; and peer group E, which are public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center; and peer group F, which are hospitals located in the State of Washington that are certified CAH.

22. *Observation Services*

Observation services means healthcare services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES

The following section describes general policies governing the reimbursement system. Payment will only be made to the provider for covered services for that portion of a patient admission during which the client is Medicaid eligible.

1. DRG Payments

Except where otherwise specified, DRG exempt hospitals, DRG exempt services and special agreements, payments to hospitals for inpatient services are made on a DRG payment basis. The basic payment is established by multiplying the assigned DRG's relative weight for that admission by the hospital's rate as determined under the method described in Section D.

Any client responsibility (spend-down) and third-party liability, as identified on the billing invoice or otherwise by the department, is deducted from the allowed amount (basic payment) to determine the actual payment for that admission.

2. DRG Relative Weights

The reimbursement system uses Washington State, Medicaid-specific DRG relative weights. To the extent possible, the weights are based on Medical Assistance (Medicaid) claims for hospital fiscal years (HFYs) 1997 and 1998, spanning the period February 1, 1997 through December 31, 1998, and on Version 14.1 of the Health Information Systems (HIS) DRG All Patient Grouper software.

The relative weight calculations are based on Washington Medical Assistance claims and Washington State Department of Health's (CHARS) claims representative of Healthy Options managed care. Each DRG is statistically tested to assure that there is an adequate sample size to ensure that relative weights meet acceptable reliability and validity standards. The relative weights are standardized to an overall case-mix index of 1.0 based on claims used during the recalibration process, but are not standardized to a case-mix index of 1.0 regarding the previous relative weights used.